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ABSTRACT

The literature on attrition points to the intake and first therapy interviews as sharing the highest dropout rates. Attrition is said to be related to client, therapist, and type-of-therapy variables. To look further into the intake session with an emphasis on client-therapist and client-clinic interaction variables, clients (N=45) rated their experience at intake on a 5-point scale designed to measure satisfaction with the clinic experience and with the intake or therapy session. Another group of clients (N=60), at a later time, were spot-checked immediately following intake session. Analyses of results indicated that the intake juncture and, to a lesser extent the first therapy session, were under the control of therapists and that therapist manner, bias, expectations, and preferences, influenced clients to continue therapy, or not. The findings suggest that therapists opt to work with appealing or challenging clients and thus may often restrict services unduly. (PAS)

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Attrition: Focus on the Intake and First Therapy Interviews

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ABSTRACT

Attrition: Focus On The Intake and First Therapy Interviews

The literature on attrition points to the intake and the first therapy interviews as showing the highest dropout frequencies (Baekeland and Lundwall, 1975; Luborsky et al., 1971). Client attrition is ascribed to client, therapist, and type-of-therapy variables. Our data looks at client-therapist interactions salient in studying attrition.

Three problems were studied: First, the occurrence of attrition following the intake session over a 5-year period (1975-1980; N = 2,254 cases). Second, ratings were provided by intake therapists on the "workability" of clients (N = 45, one semester only). On the 7-point scale for the item: "You felt you would like to work with the client," mean ratings of 4.33 for client "rejectors," 4.44 for client "dropouts" and 5.29 for client "retainers," were obtained and represent three degrees of involvement from no therapy to finishing a therapy series. These results suggested either insightful ratings or a self-fulfilling prophecy. Third, clients rated the therapist's behavior immediately following each intake and first therapy session (N = 350-400, one year's time). This portion of the study, currently under review, employs the Counselor Rating Scale and other items which study the client's evaluation of the interaction between him/her self and the therapist. It is hypothesized that ratings of both intake and first therapy sessions by client and therapist will correlate with client attrition; thus possibly leading to further realization of the importance of the intake and first therapy sessions. These are not separate therapist and client variables, but interaction effects based on evaluations by each--therapist and client--of the other for purposes of therapy.

The literature on attrition points to the intake and the first therapy interview(s) as sharing the highest dropout rates (Baekeland & Lundwall, 1975; Luborsky et al., 1971; Garfield, 1978; Frank, 1979). Attrition is said to be related to client and therapist variables and to type-of-therapy variables. Our data look more at client-therapist and client-clinic interaction variables.

Table 1 shows the overall intake, dropout (attrition), and follow-up data

Insert Table 1 about here

for 7 years, 1975-76 to 1981-82, the last year being, at this juncture, incomplete due to follow-up data not yet received.

These data show trends noted in the literature now and then but often lost sight of when discussing psychotherapy/counseling theory and practice. Table 1 brings home to us unmistakably the impact attrition shares at intake and at later interviews, under a 10-session, time-limited regimen.

Figure 1 shows the specifics of the 1980-81 period, where the total applicants for therapy are halved at the beginning of therapy (following intake)

Insert Figure 1 about here

and subsequent features, session by session throughout.

Figure 2 shows comparable figures for the 1981-82 year (incomplete) and

Insert Figure 2 about here

how the number in therapy is reduced session-by-session, down to the last session and the small surge upwards at interviews 10 and 11+.

The importance to be attributed to these findings—not unlike (but usually ignored) already existing reports in the literature—may be related

to several factors, to wit:

1. Far more people in a university setting apply for help than eventually use it. The intake interview, then, is the nub of the problem.

2. Intake and first interviews should be arranged to accommodate a goodly number of persons who can't, won't or need not carry on. Clinicians need more rounding-off interactions with clients at each juncture, from the intake interview onward. Few people need continuing therapy, and many can use a little.

3. Therapists have better ideas of what is expected in therapy than do clients (see data below) and tend to impose their standards on clients without realizing it. The therapist develops and holds the therapeutic structure and is often biased and unyielding.

4. A better introduction to therapy is needed than we now utilize—even in the short-term, 10-session limit context so that clients know more what to expect and can exercise more options regarding therapy.

To look further into the intake session we examined 45 clients as to their ratings of their experience at intake, as follows: On a 5-point scale they were asked to rate their satisfaction with their clinic experience and with the intake session, or therapy session. Clients rated the item: "You would return yourself, or recommend the clinic to others, should the occasion arise," at 4.51. The mean ratings of "terminators" ("rejectors," not going beyond the intake session); "dropouts" (going 1 or more sessions) and "remainers" (going closer to the 10-session limit) were not significantly different among these three classes of clients.

Insert Figure 3 about here

In contrast, 13 clinicians (6 staff, 7 graduate students with about two

to ten years therapy experience) rated these same client cases, on the question, "The client appeared as one who would improve with counseling or therapy" on a 7-point scale, as follows: Mean, 4.73 (total group) and mean of 4.33, 4.44, and 5.29, respectively, for rejectors, dropouts and remainers, with no significant differences between these subgroups; thus suggesting very insightful clinician behavior or a self-fulfilling prophecy.

Another study, done spring '82 semester, was based on a "spot-check" of 60 clients (42 F, 18 M) immediately following the intake session. Of these 60 actually had one or more therapy interviews. (See Figure 4 for details.)

Insert Figure 4 about here

Intervening in this process were acts—on the part of clinicians—of putting clients on "hold," having a second intake (or extended intake), or referring clients out on grounds they would do better with longer-term therapy. Of the 60 cases 15 (25 percent) said they did not know what to expect in therapy and hoped they would be told. The attrition rate at intake remained high among these cases (same as for years 1980-81 and 1981-82, as per Figures 1 and 2) and the details of interviewing suggest the therapist has, by far, the upper hand and may not be "reading" clients well.

We submit that the intake juncture—and, to a lesser extent the first therapy sessions—are largely under the control of therapists and that their manner, bias, expectations, preferences, etc. loom large in influencing clients to continue therapy or not, and also loom large in terms of explaining, or not, the therapy/counseling process. Table 1 and Figure 1-4 appear to support this generalization. In essence, therapists opt to work with those appealing to or challenging them and thus may restrict services unduly.

Conclusions reached, albeit tentatively, are that the intake is

instrumental in setting much of the entire pace of therapy and probably setting dichotomized "go-no-go" conditions on client continuing. The therapist bias is seen to be strong in several respects but needs considerably greater study.

On additional note: Theories of therapy abound—250+—and hardly a one of them has faced up to the attrition problem. In our data, we are able to follow-up, via client ratings, on something like 15-20 percent of the original, ostensibly therapy cases. If our data are typical of client loss, then the enormous selection of cases from application for therapy (intake to follow-up, would seem to throw into question existing theories of therapy and counseling. The simple fact may be that what we attribute to therapy, via theory may be missing the truth; reported gains at follow-up, in most cases, probably reflect the results of those cases bending, as it were, to therapist influences. If Eysenck's observations of 25 years ago that life experiences are about as productive of change as is psychotherapy, then these data make Eysenck even more right. If Eysenck is wrong, even then the biases afforded by attrition may make us question Eysenck less and look to better ways to retain clients, to keep on top of attrition and reevaluate follow-up data.

These data also raise questions about the selection and use of control groups. Would not the original applicants for therapy—the 50% that do not continue—be suitable controls for those who continue varying amounts of time? Would not therapist attitudes that assess readiness to work with all clients at all termination junctures be more salient than therapist's personal characteristics, theoretical leanings and the like? These are empirical questions, of course, but they are questions arising from a different perspective on client behavior and therapist attitude than has been heretofore.

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Table 1. Summary Data, 1975-1982, Inclusively, for Intake, Dropout, Therapy, and Follow-Up Evaluation Data

	1975-76		1976-77		1977-78		1978-79		1979-80		1980-81		1981-82*		1975-1982	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Males	210	45.36	162	45.64	133	41.56	202	40.00	260	42.55	135	35.16	112	39.44	1214	41.55
Females	25	54.64	193	54.37	187	58.44	303	60.00	351	57.45	249	64.86	172	60.56	1708	48.45
Totals	463		355		320		505		611		384		284		2922	
1-3 Int.	125		25		70		184		122		68		44		638	42.68
4-10 Int.	14	216	25	165	51	193	97	334	98	277	101	189	67	120	453	30.30
11+ Int.	77		115		72		53		57		20		9		403	26.96
Total No. Ther.	216	45.65	165	46.48	193	60.31	334	66.14	277	45.33	189	49.22	120	42.25	1494	51.13
Drop (Intake)	247	53.35	190	53.52	127	39.69	171	33.86	334	54.67	195	50.78	164	53.33	1428	48.67
Follow-Up Eval. vs	80		110		116		72		84		65		64			
Total Applic.	453	17.24	355	30.09	320	36.22	505	14.26	611	12.11	384	17.00	284	22.53	2922	20.22
Follow-Up Eval. vs	80		110		116		72		84		65		64		599	
No. in Therapy	216	37.03	165	66.67	193	60.10	334	21.53	277	30.32	189	34.39	120	38.03	1494	39.56
Therapist partic. in Drop	190	76.92	101	53.16	92	72.44	125	73.10	237	70.96	131	50.78	105	57.7	981	68.70
Categories																
Hold	60		16		30		05		34							
Refer	52	190	30	101	24	92	28	125	77	237	43	131	29	105		981
Terminate	78		55		38		92		126		88		76			

*Data incomplete; ends May 8, 1982

Fig 1

1980-1981 DATA

Total N Apply. for Therapy = 384 (ostensibly)

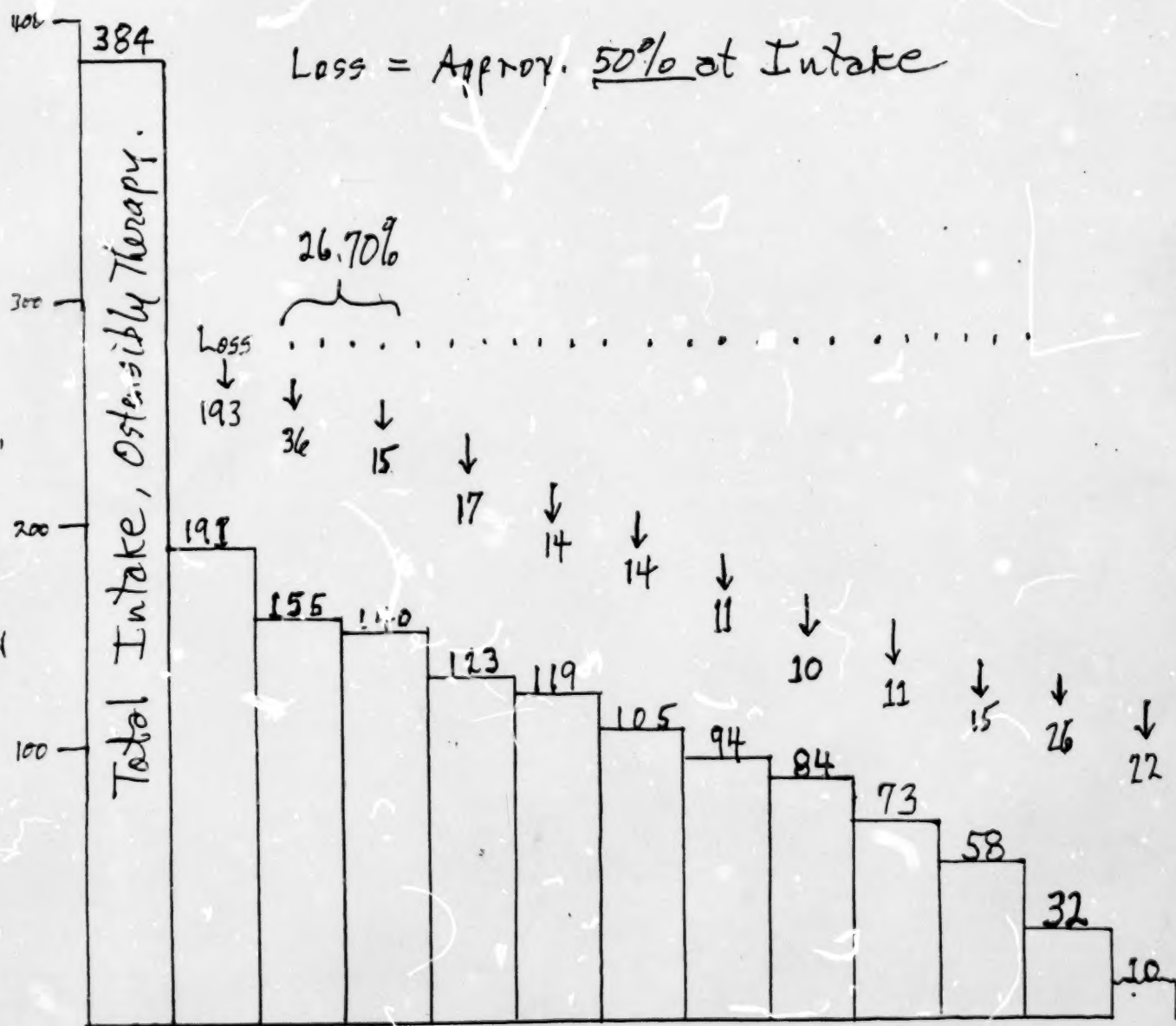


Fig 2

1981-1982 Data (Incomplete 5-8-82 cut-off)

Total N = Applic. for therapy = 284
(incomplete)

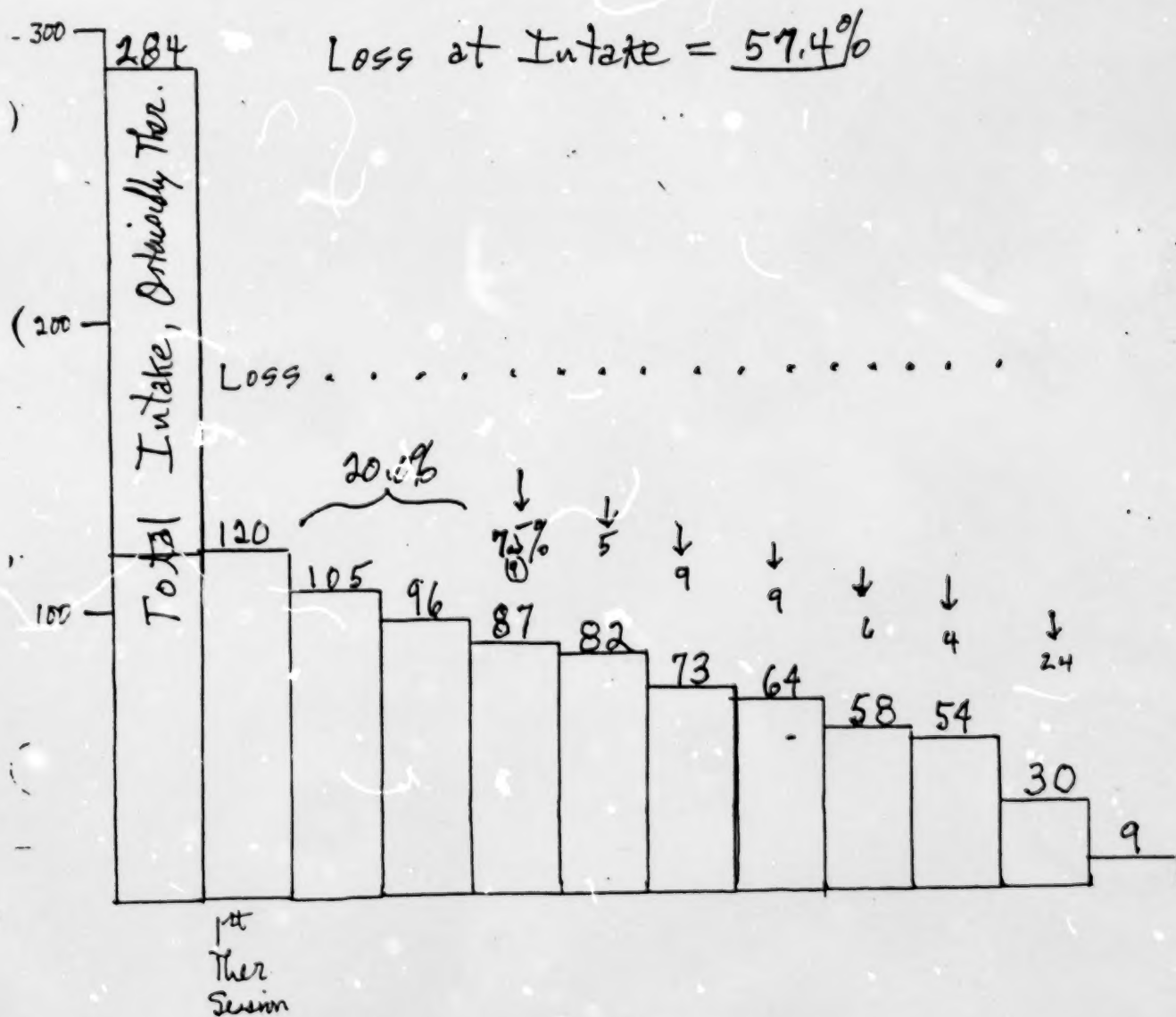


Figure 3. Client And Therapist Ratings on INTake

Client Ratings At Intake:

"...recommend clinic to others..."

N = 35 { Rejectors (Intake Only)
Dropouts (1+ Interviews)
Remainers (Ave. 7+ Sessions)

Mean Ratings
= 4.5
(5-Pt. Scale)

"...would return myself if occasion arose..."

N = 35 { Mean Ratings, 3 Client Groups,
(No Significant Differences Between
3 Client Groups); 5-Point Scale

= 4.10

Therapist Ratings At Intake:

"...Client appeared as one to improve with therapy..."

N = 45 { Rejectors
Dropouts
Remainers

Overall Mean
= 4.73; 7-Pt. Scale

Means
= 4.33
4.44
5.29

"...Would like to work with Client..."

N = 45 { Rejectors
Dropouts
Remainers

Overall Mean
= 3.67; 7-Pt. Scale

= 3.23
3.69
3.88

Figure 4. "Spot Check" Interviews Following Intake. (Spring Sem. 1982 Only)

N = 60.

Of 60 Cases, 29 (48.33%) Had 1+ Interviews, as follows:

N = 29	1 Interview	= 5	= 17.24%	} 41.39%
	2 "	= 7	= 24.14	
	3 "	= 2	= 06.53	
	4 "	= 1	= 03.44	} 31.04%
	5 "	= 3	= 10.34	
	6 "	= 2	= 06.53	
	7 "	= 0	= 00.00	
	8 "	= 0	= 00.00	
	9 "	= 1	= 03.44	} 27.58%
	10 "	= 5	= 17.24	
	11+ "	= 3	= 10.34	

(Mean, 11+ = 13.00)

N = 29 (48.33%)	No./% sought/got help before	= 29/(48.33)
	Expected to go on w Therapy	= 55/(91.66)
	Didn't know what to expect	= 15/(25.00)
	Negative response to Intake	= 05/(08.33)
	Client unilateral drop...	= 12/(41.38)
	Active Therapist participation	
	in Client drop...	= 17/(58.62)
Of 12 drop on own, only 3		
dropped at Intake (3/12)		
= 03/(25.00)		
(9 of 12 "No Show" 1st		
therap session)		
= 12/(75.00)		